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HIV-AIDS Course, Chapter 1 - Philosophy of Teachers Without Borders on HIV-AIDS Education

Personal File Storage

How to Use Your Personal File Storage

To Access your Personal File Storage

Mission Statement

Teachers Without Borders respects the extraordinary work of AIDS educators, doctors, and government agencies in Uganda. One of their particular strengths is the **A-B-C approach (A: abstinence; B: be faithful; C: condoms)**, but only when incorporated into a comprehensive program - at all levels of society - of support for stemming the tide of HIV-AIDS. We understand some of the inconsistencies in the educational program, but see them more as problems of execution, correct context, follow-through, and support, i.e. the delivery of the message. We support the inherent value of abstinence, being faithful, and using condoms.

The key, however, in terms of the education community, is the incorporation of A-B-C principles into other programs supporting young people's self-esteem and integrity, civil rights, the protection of girls and support for their general education, and a growing set of circles of capacity in each community - in health, in sanitation, in the quality of life, in economic opportunity, and in political freedoms and rights.

Furthermore, Teachers Without Borders' own research has led us to the conclusion that **testing must be pervasive and frequent and confidential**. Many AIDS analysts assert that testing must be required "at three specific moments in a person's life: at marriage, before childbirth, and upon any visit to a hospital. At these moments (and, we hope, others), public health criteria legitimately take priority over the desire of the individual." (**New York Times**, February 10, 2004: "A Global Battle's Missing Weapon."). Clearly, Teachers Without Borders promotes the right to privacy and the

freedom of the individual. However, in light of the AIDS pandemic, some sacrifices need to be made.

Once again, testing must be **pervasive** - testing across age, economic, geographic, and social strata of society. Testing must be **frequent** - even faithful, monogamous couples can be H.I.V. "discordant" in which one of the partners in the marriage was infected and the other, not, by a previous partner. The virus incubates for approximately eight years. Finally, testing must be **confidential**.

We view HIV-AIDS as a societal, as well as medical epidemic, and so work to promote education on HIV-AIDS, along with an enhanced general education. We also support international agencies and local NGOs in their attempts to improve the infrastructure of information sharing, medical facilities for treatment and other viable and quantifiable programs on prevention including those programs that may advocate condom distribution.

Teachers Without Borders works to close the education divide and to respect the hearts and minds of all. **HIV-positive people must NOT be stigmatized**. We welcome the ranks of HIV-positive persons into the ranks of our organization and depend upon them - as we do everyone of good intention - to work on behalf of education.

It is our policy to work with all sectors in the battle against HIV-AIDS, provided their work does not conflict with empirical evidence on both treatment and prevention best practices. Furthermore, we shall not work with agencies who stigmatize HIV-infected and affected people.

There is a window of hope available to us, through education. In fact, a fascinating article, A Window of Hope, describes the situation we are in today:

[Window of Hope](#)

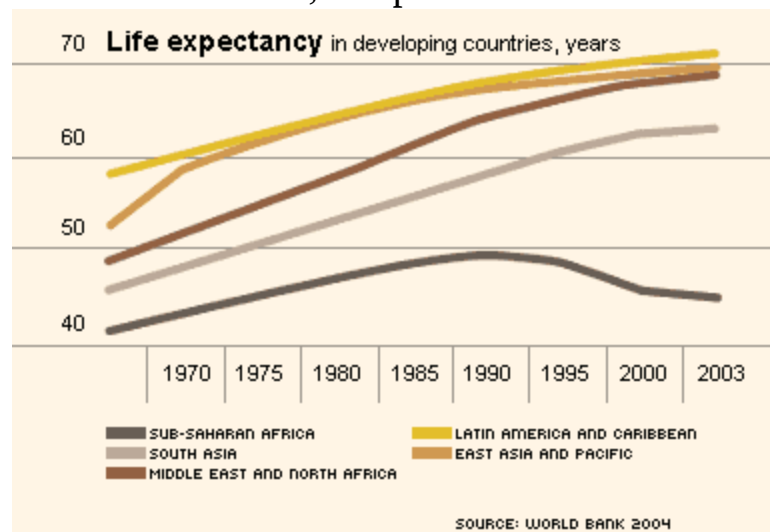
To get to the next page, look at the right side of this screen. You'll see a blue bar towards the bottom.

Look underneath the blue bar and click on the word "Outline." If you click on "Outline," a screen will "pop up" that will show you the outline for this entire course. Click on the next topic in black that says "Frequently Asked Questions."

Once you're in this new section, you'll simply click "Next" to go to the next page. The "Next" button is to the right of the blue bar. Whenever you wish to go back to a previous page, look to the left of the blue bar and click on the word "Previous." This takes you back one page.

Note: When you come to the end of a section, as you are now about to do, you **MUST** use the "Outline" button and choose the next topic and click on it in order to get to it.

HIV-AIDS Course, Chapter 2 - HIV-AIDS Basics for Teachers



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Frequently Asked Questions

Here are several questions often asked about HIV and AIDS. We will address these questions through this course. We have also provided a good overview: [Facts and Myths About AIDS](#), which can give teachers a good grounding on the subject.

PDF Version below:

[Facts and Myths About AIDS](#)

This information, in poster form (tested successfully in Uganda) answers some of the questions below:

Questions:

- What is HIV?
- What is AIDS?

- How quickly do people infected with HIV develop AIDS?
 - How many people are affected by HIV/AIDS?
 - How is HIV transmitted?
 - How is HIV not transmitted?
 - How can I reduce my risk of becoming infected with HIV through sexual contact?
 - How can I avoid acquiring HIV from a contaminated syringe?
 - Is there a link between HIV and other STDs?
 - Are there other ways to avoid getting HIV through sex?
 - Are some people at greater risk of HIV infection than others?
 - Are women especially vulnerable to HIV?
 - Are young people at significant risk of HIV infection?
 - Are there treatments for HIV/AIDS?
 - Is there a cure for AIDS?
 - Is there a vaccine to prevent HIV infection?
 - Can you tell whether someone has HIV or AIDS?
 - How can I know whether I'm HIV-infected?
 - Should I get tested?
 - How can I get tested?
 - Where can I get more information about HIV and AIDS?
 - How can I help fight HIV/AIDS?
-

Note: The title at the top of the page, "A Practical Guide to Prevention, Health, and Life," is in blue. This is a PDF file and can be accessed by simply clicking on the blue words. Often, you'll be able to click on the blue words and access PDF files. Other times, however, the blue words are a link to a site, and in order to access the site, you need to be connected to the Internet.

Useful Resources for Teachers on HIV and AIDS

[Common Questions About HIV/AIDS](#)

(online only - U.S. focused) Full Manual on HIV-AIDS (with pictures): This manual describes the symptoms as well as treatments in a language clear and simple enough for all to understand. Basic Knowledge on HIV-AIDS/STD This site was developed by UNESCO and includes information from which students can be quizzed to judge their knowledge of the subject.

[Children orphaned by HIV/AIDS : Strategies for Hope:](#) (online only) An excellent model that encourages community mobilization around HIV/AIDS (i.e. to get people involved in HIV/AIDS prevention and care efforts) They use the Stepping Stones community training curriculum. National and Regional NGO links (country by country): This is a good source to find out what is happening in HIV-AIDS education around the world.

Additional Resources (PDFs)

[AIDS Basics](#)

More Basic Knowledge

HIV

HIV is a virus. Illnesses caused by a virus cannot be cured by antibiotics. (Although medicines may help to reduce the symptoms) People who have a virus - such as a cold - usually get better after a few days or weeks because the white blood cells of the immune system - which are responsible for fighting diseases - successfully overcomes them.

When a person is infected with HIV, the immune system tries to fight off the virus and does make some antibodies, but these antibodies are not able to defeat HIV.

The person is said to be HIV Positive. Many people do not feel ill at all when they are first infected. They may have no symptoms for a long time. They have not yet got AIDS.

HIV acts by gradually destroying the immune system of the infected person. After about 5 to 10 years (although much earlier in a minority of

cases) the immune system becomes so weak - or 'deficient'- that it cannot fight off infections as it used to. (For reading sources, click [here](#).)

HIV is found in body fluids such as blood, semen, vaginal fluids and breastmilk. It is passed from one person to another - or transmitted - only in very specific ways. These are:

- through sexual intercourse between a man and a woman or between two men;
- through infected blood - for example through contaminated blood transfusions or unsterilised needles and syringes. (In most places today blood transfusions are completely safe because the blood is tested for HIV before it is used to treat patients); and
- from an infected mother to her baby while it is still in the womb or during childbirth or during breastfeeding.

HIV does not spread through "casual" everyday contact between people.

It is not transmitted by coughing, or sneezing, or by touching or hugging someone who has the virus.

It is not spread in air, water or in food, or by sharing cups, bowls, cutlery, clothing, or toilet seats.

And HIV is not transmitted by biting insects such as mosquitoes, because the quantity of blood on their mouthparts is too minute. (For reading source, click [here](#).)

Further Resource: [UNAIDS](#)

AIDS

Eventually the infected [HIV] person may lose weight and become ill with diseases like persistent severe diarrhea, fever, or pneumonia, or skin cancer. He or she has now developed AIDS.

At the moment, in spite of much research, there is no cure for HIV or for AIDS and so, sadly, it is almost certain that people diagnosed with AIDS

will die. (For reading sources, click [here](#).)

The Role of Culture

Around the world a variety of cultural practices and traditions increase young people's risk for HIV/AIDS. For the most part, these practices and traditions affect young people more than adults - and affect young women even more than young men.

Women's Status

In many societies women are expected and taught to subordinate their own interests to those of their partners. With such expectations, young women often feel powerless to protect themselves against HIV infection and unintended pregnancies. Often, adolescent girls endure sexual coercion and abuse. In Kenya 40% of sexually active female secondary school students said that they have been forced or tricked into sex (3). In Cameroon 40% of female adolescents reported that their first intercourse was forced (313). Young women sometimes give in to having sex for fear that, if they refuse, they will be raped anyway (205).

Wife abuse is widespread. In some countries more than 40% of women have been assaulted by their partners (119). Gender-based violence is closely linked to HIV/AIDS (220). In Rwanda, for example, HIV-positive women with an HIV-positive partner were more likely to report sexual coercion in their relationship than were women without HIV (380). In Tanzania partner violence was 10 times higher among young HIV-positive women than HIV-negative women (220). Many women do not dare even to bring up the topic of condoms for protection against HIV infection for fear that they will be physically abused (381).

Marriage Practices

In many cultures, the premium placed on having children often leads to childhood marriage and early childbearing. Girls as young as age 10 are given to older men in marriage in order to cement friendships and economic ties between families. When girls are married to older men, they can be

vulnerable to HIV infection because their husbands usually have already had a number of sexual partners. Social, political, and religious barriers often hide young wives from the world (423), while their husbands frequently have other sexual partners (12).

Polygyny, the practice of a man having multiple wives, occurs in some countries. In Africa, when the husband seeks a new, often younger, wife, he may have sexual contact with a number of women in the process and thus risk bringing HIV home (7, 12, 41). In some cultures, wife inheritance is practiced - a tradition in which a wife is given to her brother-in-law upon her husband's death. Thus, either partner can be at risk of HIV infection if the other is infected. Younger widows are at particular risk because they are more likely to seek and be sought by other sex partners (6, 277, 321).

In some societies payment of bridal dowry is necessary when a man and woman marry. In parts of Africa the man pays the dowry to the woman's family. Once the marriage is sealed with the dowry, the woman is considered "paid for" and often cannot leave her husband, should marital problems ensue. Even if her husband's behavior places her at risk of HIV infection, the woman may not be able to protect herself (119).

Rites of Passage

Cultural rites of passage from childhood into adulthood, although traditionally serving to unite communities, can increase risks for HIV. For example, traditional male or female circumcisions are sometimes carried out using unsterilized equipment. Researchers think that male circumcision reduces risks for HIV transmission by removing part of the foreskin that is particularly vulnerable to HIV. In some communities, however, circumcision ceremonies often are accompanied by post-initiation sexual experimentation, which increases risks for HIV (174, 350). For example, among the Maasai of East Africa the relationship among male peers is so close that, after circumcision, the initiates share wives and girlfriends.

Sexual Practices

Some sexual practices such as dry sex-the insertion of foreign objects to dry the vagina or to make it tighter -can cause cuts and scratches that create

openings for HIV to pass through (321). Other practices, such as virginity testing of women, may place such a high premium on chastity before marriage that unmarried women practice anal sex instead, putting themselves at even greater risk for HIV/AIDS than if they had vaginal sex (341).

Assignment 1 - Your Context and Community

We would like you to describe the challenges and opportunities facing you and your school in terms of HIV-AIDS Education, by providing us with information.

There are FOUR ways in which you can send your responses to your HIV-AIDS Mentor.

1. Copy and paste (or retype) the questions to a file and send them to your instructor via email. The address is:
hiv@teacherswithoutborders.org
2. Upload the file to your Personal File Storage. To do so, save this as a Word file (doc) or a txt file (txt). When you log on as a Learner to the HIV-AIDS for Educators course, you'll see a place where you can upload files to your instructor. If you need more instructions about this, please click on Outline and view the section: "How To Use Your Personal File Storage." [Assignment 1: Your Context and Community](#).
3. Send it to an online survey for us to use as research. Click [here](#) for the online link to the online survey.
4. You can send the survey in the post to the following address:

HIV-AIDS Mentor

Teachers Without Borders

2880 74th Avenue, S.E.

Mercer Island, WA 98040

U.S.A.

—

HERE ARE THE QUESTIONS for Assignment 1 - Your Context and Community

Please describe the challenges and opportunities facing you and your school in terms of HIV-AIDS Education, by providing us with information.

1. What, if any, HIV-AIDS education takes place? Describe the curriculum in general terms, along with any points of view or orientation the school or community wishes to emphasize. On the subject of condoms, for example (described in more detail later on in this course), some schools stress condom use; others avoid the subject; still others are against it. We are not asking for a point of view with which we agree - just the truth.
2. What are the incentives to conduct HIV-AIDS education?
3. What are the obstacles to conducting HIV-AIDS education?
4. Is there a voluntary HIV-AIDS testing facility near by? If so, are the tests free? If not, how much do they cost? Is there fear associated with HIV-AIDS testing? Is there stigma associated with HIV-AIDS testing?
5. If young people are tested positive, do they have a place to go for treatment? If there is a place, is it adequate? Describe what causes some people to go and what causes others not to go.

This is the last page of this section. To get to the next section, you **MUST** use the "Outline" button and choose the next topic called "Guidelines for the Surveys" - written in black - and click on it in order to get to it.)

HIV-AIDS Course, Chapter 3 - Digging Deeper: Assessing Attitudes Using Youth Surveys

Guidelines for the Surveys

This next section includes several surveys, touching on all aspects of student life in and beyond classrooms, in families, in social settings, and in privacy. The surveys have been assembled to assist developing country researchers in knowing the students they teach and in designing programs and curricula that make an impact. The surveys contain a wealth of questions obtained from several different existing surveys on adolescent reproductive health.

The questions are sorted into sections, which were chosen to reflect the wide range of adolescent reproductive health issues. Like all surveys, questions should be adapted to local contexts.

PLEASE VIEW THE SURVEYS AS LEARNING OPPORTUNITIES, RATHER THAN OBLIGATIONS OR DATA GATHERING. USE THEM AS KEYS TO DESIGNING A PROGRAM THAT FITS YOUR NEEDS.

The categories may appear to overlap. Please review related sections to find the questions you need.

There are **THREE** ways in which you can send your responses to your HIV-AIDS Mentor.

1. Copy and paste or retype the questions to a file and send them to your instructor via email. The email address is:
hiv@teacherswithoutborders.org.
2. Upload the file to your Personal File Storage. To do so, save this as a Word file (doc) or a txt file (txt). When you log on as a Learner to the HIV-AIDS for Educators course, you'll see a place where you can upload files to your instructor. If you need more instructions about this, please click on Outline and view the section: "How To Use Your Personal File Storage."
3. You can send the survey in the post to the following address:

HIV-AIDS Mentor

Teachers Without Borders

2880 74th Avenue, S.E.

Mercer Island, WA 98040 U.S.A.

Students and Risk

Included in this section on Risk Behaviors are 3 surveys. These 3 surveys must be conducted in an honest, confidential atmosphere. Students must be assured that the information collected SHALL NOT be used against individuals.

No information will be used against anyone else they mention. All of these surveys are only a general measure of how a given community can assess the knowledge and behavior base of a community. With good information in hand, then a community can build the kind of successful program that will stem the tide HIV-AIDS in their community.

Survey 1: [Smoking, Drugs, and Alcohol](#) (online)

[Smoking, Drugs, and Alcohol](#)

Survey 2: [Risk Behaviors](#) (online)

[Risk Behaviors](#)

Survey 3: [Delinquency](#) (online)

[Delinquency](#)

Sending Responses to TWB

There are **THREE** ways in which you can send your responses to your HIV-AIDS Mentor or TWB.

1. Copy and paste or retype the questions to a file and send them to your instructor via email. The email address is:
hiv@teacherswithoutborders.org.
2. Upload the file to your Personal File Storage. To do so, save this as a Word file (doc) or a txt file (txt). When you log on as a Learner to the HIV-AIDS for Educators course, you'll see a place where you can upload files to your instructor. If you need more instructions about this, please click on Outline and view the section: "How To Use Your Personal File Storage."
3. You can send the survey in the post to the following address:

HIV-AIDS Mentor Teachers Without Borders 2880 74th Avenue, S.E.
Mercer Island, WA 98040 U.S.A.

Surveys on Leisure Activities

Included in this section on Leisure Activities are 3 surveys:

1) Survey 1: [Social Networks, Activities, and Media](#)

[Social Networks, Activities, and Media](#)

2) Survey 2: [Future Goals and Opportunities](#)

[Future Goals and Opportunities](#)

3) Survey 3: [Psychosocial Concerns and Sexuality](#)

[Psychosocial Concerns and Sexuality](#)

Surveys on Social Support and Sex Education

Included in this section are 3 surveys. These 3 surveys must be conducted in an honest, confidential atmosphere. Students must be assured that the information collected SHALL NOT be used against individuals.

No information will be used against anyone else they mention. All of these surveys are only a general measure of how a given community can assess the knowledge and behavior base of a community. With good information in hand, then a community can build the kind of successful program that will stem the tide of HIV-AIDS in their community.

Survey 1: [Social Networks and Activities](#)

[Social Networks and Activities](#)

Survey 2: [Family Relationships and Risk Taking](#)

[Family Relationships and Risk Taking](#)

Survey 3: Sex Education and Communication ([PDF](#))

[Sex Education and Communication](#)

Surveys on Sexual Relationships

This survey has to do with intimate subjects. Proceed with caution and look for the safest place for teens to respond to this survey. **Please assure them as well that this information will NOT be used against any individual, but rather as an information-gathering exercise in order to stem the tide of HIV and AIDS.**

These 3 surveys must be conducted in an honest, confidential atmosphere. Students must be assured that the information collected SHALL NOT be used against individuals. No information will be used against anyone else they mention. All of these surveys are only a general measure of how a given community can assess the knowledge and behavior base of a community. With good information in hand, then a community can build the kind of successful program that will stem the tide HIV-AIDS in their community.

There are 3 surveys here:

1) **Sexual Practices, Partners, and Pregnancy 1** ([PDF](#) file). This survey has to do with masturbation, sexual attraction and "crushes," homosexuality, dating behavior, commercial sex, coercion, sexual encounters, pregnancy outcomes and surveys for new mothers.

[Sexual Practices, Partners, and Pregnancy - Dating](#)

2) **Sexual Practices, Partners, and Pregnancy 2** ([PDF](#) file). This survey continues from the section on pregnancy outcomes and addresses questions having to do with issues surrounding a single - or multiple - births.

[Sexual Practices, Partners, and Pregnancy - Pregnancy Outcomes](#)

3) **Sexual Practices, Partners, and Pregnancy 3** ([PDF](#) file). This survey asks questions to extend the first survey and focuses on: commercial sex, coercion, and other sexual encounters.

[Sexual Practices, Partners, and Pregnancy - Sex Acts](#)

Surveys on Contraceptive Use

These 2 surveys have to do with attitudes toward the use of contraceptives and deal with intimate subjects. Proceed with caution and look for the safest place for teens to respond to this survey. Please assure them as well that that this information will NOT be used against any individual, but rather as an information-gathering exercise in order to stem the tide of HIV and AIDS.

Please **SEND** these surveys to us **EITHER** by email to this address: (hiv@teacherswithoutborders.org) OR post your responses to your Personal File Storage. If you choose to post your responses to your Personal File Storage, please name them correctly. Example: Survey 1, Survey 2, Survey 3, etc.

Survey 1: [Knowledge and Attitudes](#)

[Knowledge and Attitudes](#)

Survey 2: [Contraceptive Use](#)

[Contraceptive Use](#)

Surveys on Attitudes toward STDs and HIV/AIDS

These 3 surveys have to do with attitudes toward the use of contraceptives and deal with intimate subjects. Proceed with caution and look for the safest place for teens to respond to this survey. Please assure them as well that that this information will NOT be used against any individual, but rather as an information-gathering exercise in order to stem the tide of HIV and AIDS.

Survey 1: [Knowledge and myths](#)

[Knowledge and myths](#)

Survey 2: [Background and practices](#)

[Background and practices](#)

Survey 3: [Communication and education](#)

[Communication and education](#)

Surveys on Health Seeking Behaviors

These 2 surveys must be conducted in an honest, confidential atmosphere. Students must be assured that the information collected SHALL NOT be used against individuals, but as a measure to assess the ingredients of a successful program to stem the tide HIV-AIDS in their community.

Survey 1: [Access to Healthcare](#)

[Access to Healthcare](#)

Survey 2: [Motivation and willingness to pay](#)

[Motivation and willingness to pay](#)

Surveys on Reproductive Health

These 2 surveys must be conducted in an honest, confidential atmosphere. Students must be assured that the information collected SHALL NOT be used against individuals. No information will be used against anyone else they mention. All of these surveys are only a general measure of how a given community can assess the knowledge and behavior base of a community. With good information in hand, then a community can build the kind of successful program that will stem the tide of HIV-AIDS in their community.

Survey 1: [Reproductive Health Knowledge](#)

[Reproductive Health Knowledge](#)

Survey 2: [Self Awareness](#)

[Self Awareness](#)

Surveys on Social Norms and Gender Roles

These 3 surveys must be conducted in an honest, confidential atmosphere. Students must be assured that the information collected SHALL NOT be used against individuals. No information will be used against anyone else they mention. All of these surveys are only a general measure of how a given community can assess the knowledge and behavior base of a community. With good information in hand, then a community can build the kind of successful program that will stem the tide of HIV-AIDS in their community.

There is NO intention to tell a community that their cultural traditions are wrong or bad. Rather, it is our intention to provide the most respectful ways of providing empowering information that can save lives. It is our intention that the surveys be used in that spirit.

Survey 1: [Social Norms and Gender Roles](#)

[Social Norms and Gender Roles](#)

Survey 2: [Taboos and Customs](#)

[Taboos and Customs](#)

Survey 3: [Peer Influence](#)

[Peer Influence](#)

HIV-AIDS Course, Chapter 4 - Sexuality and Personal Relationships

Sexual Development Awareness

This is the kind of message we hope youth can hear:

"The importance sexuality has in your life will change at different times, and you may not always be sexually active or want to be. Like any other subject, sex education should be accurate, enable you to make informed choices and give answers and solutions to your own concerns. Whatever your starting point, your experience is an individual one, and you are already on this journey. It is, however, often an experience of life or death."

(For reading source, click [here](#).)

Unprotected Sex

Having unprotected sex (anal, oral or vaginal) and/or sharing unclean needles such as intravenous drug syringes (the works) and needles used for tattooing and body piercing with a person who is HIV positive or unaware of his/her HIV status are all actions that put you at risk.

The use of drugs and/or alcohol can make it harder for you to practice safer sex and to set limits for yourself.

In 8 out of 10 cases, HIV is transmitted during sex between a man and a woman or between two men.

The virus is passed on when infected blood, semen, or vaginal fluids from one partner enters the body of the other partner through the very thin skin of their sex organs, mouth or anus, or through sores or cuts on their mouth, hands or body.

Dry sex increases the risk of HIV transmission because friction can cause sores in the vaginal wall.

Girls and Virginity

A virgin is someone who has not had sexual intercourse. Women have a membrane called a hymen surrounding the vaginal opening. The hymen can be stretched and/or torn by exercise, sports or the use of tampons. The presence of the hymen is not a sign of virginity. Some people believe that the hymen is the only proof of virginity. This belief can cause a lot of unhappiness and anxiety to a woman who has no hymen, but is a virgin.

Having penetrative sex for the first time can be scary. The need for gentleness and understanding is very important. The hymen is not a wall that needs to be battered down. The first act of sexual intercourse will not necessarily cause bleeding. The first time can be painful or sore whether you are a male or female. And you can become pregnant the first time you have sex. Do not have sex if you don't want to.

Menstruation

Girls are born with thousands of potential or immature eggs in each of their 2 ovaries. After puberty, one mature egg is released every month. This is called ovulation and happens around 14 days before a 'period' is due. If the egg is not fertilized by sperm, it will die and pass out of the body through the vagina as a period, along with the lining of the womb. The egg can't be seen as it's much too small. The menstrual cycle varies from 21 days to 40 days. Not all women have regular periods.

Changes in hormone levels before or during your cycle can affect your mood. You may feel energetic and sexy around ovulation and/or moody, tearful and angry just before your period is due. Your breasts may become sore or a bit larger and you may get spots on your face. Women release eggs until they reach menopause. Menopause occurs when women are in their late 40s and 50s and menstruation stops and they cannot become pregnant.

Changes During Puberty

Puberty happens to every young person some time after the age of 8. It is the transition into woman/manhood when the sex organs grow and develop and the body becomes ready and able to reproduce. These changes can

make you feel proud and happy, and they can also make you feel confused or embarrassed.

- Your height, weight, and muscles develop
- Your sex organs grow
- You become fertile
- The glands in your skin become more active and can give you spots
- Your sweat glands develop
- Hair starts to grow under your arms and around your genitals
- You may experience rapid mood swings
- You may begin to be attracted towards members of the opposite or same sex

Changes that affect girls:

- Your breasts develop and may feel painful as they grow
- Your nipples begin to stand out
- Your hips get rounder
- Your ovaries start to produce ova or egg cells
- Later in puberty, menstruation starts

Changes that affect boys:

- Your chest and shoulders develop
- Your voice deepens
- Hairs start growing on your face and may grow on your chest
- Your penis and testicles grow larger
- Your testicles drop into the scrotum and start to produce sperm
- You may have erections without warning
- You will experience your first ejaculation when liquid called semen comes out of your penis (this can also happen when you are asleep.)

The A-B-C Approach

Abstaining from sexual activity, faithfulness, and condom use are three behaviors that can prevent or reduce the likelihood of sexual transmission of HIV infection. These behaviors are often considered together as the

"ABCs" of HIV prevention - **A** for abstinence (or delayed sexual initiation among youth), **B** for being faithful (or reducing one's number of sexual partners), and **C** for condom use, especially for casual sexual activity and other high-risk situations.

Understanding and promoting these behaviors are key elements in combating the spread of HIV/AIDS. Based on a growing body of evidence from a number of developing countries, USAID supports the ABC approach because it can target and balance A, B, and C interventions according to the needs of different at-risk populations and the specific circumstances of a particular country confronting the epidemic.

Background: The Decline of HIV Prevalence in Uganda

As one of the world's earliest success stories in confronting AIDS - and probably the most dramatic - Uganda experienced substantial declines in HIV prevalence during the 1990s. According to estimates by the U.S. Census Bureau and UNAIDS, national prevalence peaked at around 15 percent in 1991 and fell to 5 percent by 2001. Among pregnant women in urban areas, prevalence declined from a high of approximately 30 percent to about 10 percent, while among rural pregnant women it fell from more than 10 to less than 5 percent. Uganda's vivid decline in HIV prevalence remains unique worldwide. In other sub-Saharan African countries with epidemics of comparable severity and longevity, similar declines have yet to occur. Accordingly, Uganda's success has been the subject of intense study and analysis.

It is now clear that Uganda's decline in HIV prevalence followed positive changes in all three ABC behaviors: increased abstinence, including deferral or greatly reduced levels of sexual activity by youth since the late 1980s; increased faithfulness and partner reduction behaviors; and increased condom use by casual partners. In Uganda's particular circumstances, the most significant of these appear to be faithfulness or partner reduction behaviors by Ugandan men and women, whose reported casual sex encounters declined by well over 50 percent between 1989 and 1995. This conclusion is supported by comparisons with other African countries.

In addition, abstinence, deferral of sexual activity by youth, and condom use played substantial roles in reducing HIV prevalence. Uganda's successful combination of ABC approaches appears rooted in a community-based national response in which both the governmental and nongovernmental sectors, including faith-based organizations, succeeded at reaching different population groups with different messages and interventions appropriate to their need and ability to respond. Young persons who had not yet begun to have sex were cautioned to wait. If a young person had just begun to have sex, then he or she should return to abstinence. If a person was already sexually active, he or she should adopt the practice referred to locally as "zero grazing" - faithfulness in marriage or partner reduction outside of marriage. For those who could not heed this advice, free and affordable condoms were distributed and promoted.

Evidence From Other Countries

While Uganda provides the most dramatic example of the effect of ABC behavior changes on slowing the spread of HIV infection, there is growing evidence from other countries as well. In Thailand, the first Asian country to face a severe AIDS epidemic, commercial sex was the main source of HIV infection. In the early 1990s, the government successfully instituted a "100 percent condom use" policy in commercial sex establishments, and this policy was widely credited with drastically reducing the spread of HIV infection. In addition to increased condom use, between 1990 and 1995 the proportion of men reporting paying for sex also declined by more than 50 percent. In addition to condom use, partner reduction in Thailand undoubtedly had a substantial effect on slowing the country's HIV/AIDS epidemic. As in Uganda, the government's willingness to address the epidemic openly was crucial.

Zambia, Cambodia, and the Dominican Republic are other countries in which various combinations of ABC behaviors have contributed to declines in HIV prevalence. In Zambia, some decline in prevalence appears to have occurred among urban youth during the 1990s, during which time national surveys reported clear, positive changes in all three ABC behaviors. The grassroots involvement of faith-based and other community-based organizations was crucial in promoting these changes. As occurred in

Uganda, the main reported change was a large decline in casual sex among both men and women. Cambodia is replicating Thailand's success in applying a 100 percent condom policy in commercial sex establishments. Also similar to Thailand, the country has experienced a steep decline in the number of men visiting sex workers (from 27 to 11 percent between 1996 and 2000). In the Dominican Republic, partner reduction by men and increased condom use with non-regular sexual partners also appear to have slowed the spread of infection.

Balancing and Targeting a Comprehensive ABC Approach

A USAID-funded review of data finds the need for appropriately balanced and targeted ABC approaches. This study has analyzed how ABC behaviors appear to have affected HIV prevalence in three countries where prevalence has declined (Uganda, Zambia, and Thailand) compared to three countries where there is little evidence of a decline (Cameroon, Kenya, and Zimbabwe). In the case of the five African countries, it found that significant delays in the onset of sexual activity, declines in premarital sex, and large declines in extramarital sex and multiple sexual partnerships occurred in Uganda and Zambia during the 1990s, while comparable changes appear not to have occurred in Cameroon, Kenya, or Zimbabwe. Condom use increased greatly in all of the countries.

In September 2002, USAID hosted a meeting of technical experts from HIV/AIDS programs and research institutions to consider the evidence regarding ABC behavior change approaches to HIV prevention. The meeting identified areas of consensus that may have important implications for program planning and decision making:

There is a clear need for a balance of A, B, and C interventions. One approach should not be favored over another. Approaches should instead be combined as appropriate based on the local cultural context as well as the state of the HIV epidemic.

Interventions need to be targeted for efficiency and respond to crucial differences among target groups. For example, balanced ABC approaches might be implemented in the form of A interventions promoting sexual deferral to youth; B interventions promoting partner reduction to those not

in monogamous relationships; and C interventions promoting condom use to highly sexually active groups, especially sex workers and their clients, and people living with HIV/AIDS.

The nature of the epidemic is a major factor in determining the appropriate balance. In Southeast Asia, HIV/AIDS is still largely confined to high-risk populations, in which correct and consistent condom use is relatively easy to implement. In many African countries, the epidemic is more generalized and thus requires an appropriate mix of A, B, and C approaches.

Continuing studies are needed. Continuing studies in other countries will yield more evidence of the most effective balance of ABC approaches in different settings. Senegal, for example, has achieved Uganda-like behavior change with a balanced ABC program in a low-prevalence setting. Further study of such successes is needed to consider their potential application elsewhere.

The A-B-C Approach: Abstinence

Abstinence means avoiding sex. Sex can have different definitions for different people. Some people define sex as penis-in-vagina intercourse. Others may include oral sex, anal sex, or even kissing and touching. The way you define "sex" determines what activities to avoid if you want to abstain. For the purpose of this page, we will focus on abstaining from penis-in-vagina intercourse because the goal of these materials is to help you prevent pregnancy.

Please remember that it's OK to go through periods of your life, or periods of time within a single relationship, in which you want to abstain and periods in which you want to have sex. The decision to have sex is YOUR decision, each and every time.

Advantages:

- Abstinence is free and available to everyone.
- It's extremely effective at preventing both pregnancy and infection.
- It can be started at any time in your life.

- Abstinence may encourage people to build relationships in other ways.
- It may be the course of action which you feel is right for you and makes you feel good about yourself.

The A-B-C Approach - Be Faithful

To "B-e Faithful" as a means of AIDS prevention means to remain loyal to one's sexual partner. By doing such, one lowers the risk of exposure to HIV-infected individuals. By choosing to remain in a faithful, committed relationship each partner is choosing to be exclusive and only have sexual intercourse with one another. Thus, if you choose to be sexually active, rather than to abstain from sex, being faithful to your sexual partner is the next step in the ABC prevention plan as a way to reduce the risk of transmitting HIV.

The A-B-C Approach: Condoms

Studies have shown that latex condoms are highly effective in preventing HIV transmission when used consistently and correctly. These studies looked at uninfected people considered to be at very high risk of infection because they were involved in sexual relationships with HIV-infected people. The studies found that even with repeated sexual contact, 98-100 percent of those people who used latex condoms correctly and consistently did not become infected.

For more information, click [here](#) (online only)

HIV-AIDS Course, Chapter 5 - HIV-Infected Children

Budding baseball player in Havana



Photograph courtesy of Robert Leon

Contamination

If blood from a person infected by HIV gets into the blood stream of another person, it will infect them also with the HIV. This can happen:

- **If contaminated instruments are used to pierce the skin during:**
 - injections
 - circumcision
 - scarrification
 - ear piercing
 - tatooing
 - acupuncture

(Infection can be prevented if the equipment used is brand new, or is carefully sterilized each time it is used.)

- **From a blood transfusion with infected blood**

Blood transfusions may be necessary:

- after a bad accident, if someone has lost a lot of blood;
- during a hospital operation;
- after childbirth, if the mother has lost much blood; or
- if a person is anaemic due to bilharzia, hookworm or malaria parasites.

If the blood or equipment used is contaminated with HIV, this will be transmitted to the person receiving the blood, and so they will also become infected.

All equipment used for blood transfusions should be sterilized before it is used. In some countries all blood which has been donated is tested for HIV infection, and only non-infected blood is used. More and more countries are now trying to do this.

There is no risk in donating blood if the equipment is new or properly sterilized.

(For reading source, click [here](#).)

How does AIDS affect the eyes?

Cotton Wool Spots - AIDS can cause tiny amounts of bleeding and white spots in the retina. These white spots are called cotton wool spots.

CMV Retinitis - A serious infection of the retina is caused by cytomegalovirus (CMV).

About 20-30% of people with AIDS have CMV. Most infections happen when the number of T-cells gets dangerously low, usually under 40. CMV can damage the eyes permanently.

Signs of CMV include:

- Floating Spots
- Flashing Lights
- Blind Spots or Blurred Vision

Red Eye - People with AIDS sometimes have persistent infections.

Detached Retina - Sometimes CMV causes the retina to separate from the back of the eye. A detached retina can cause a serious vision loss. Surgery is the only means of reattaching a detached retina.

Kaposi's Sarcoma - Kaposi's sarcoma (KS) is a kind of tumor that looks like a bump on the eyelid or a spot on the white part of the eye. KS grows slowly and does not harm the eye.

What are the treatments for AIDS eye problems?

There are two drugs to fight CMV infections. These drugs do not cure CMV, only slow it down. It is important to see an ophthalmologist for regular eye exams in case CMV flares up. Early detection of CMV is vital to a positive outcome and if only one eye is infected, the patient can protect the other eye by taking anti-CMV medicines.

Kaposi's sarcoma can be treated with radiation, laser surgery, freezing or surgery.

Each disease has its own treatment. An ophthalmologist should be consulted for an accurate diagnosis.

Nutrition

HIV/AIDS and malnutrition are interrelated. In fact, in Africa AIDS was initially known as 'slim disease' because of the wasting syndrome typically experienced by people with the disease. Research suggests that malnutrition increases the risk of progression of HIV infection, and it may also increase the risk of HIV transmission from mother to baby. In turn, HIV infection makes malnutrition worse through its attacks on the immune system and its impact on nutrient intake, absorption and the body's use of food.

Malnutrition associated with HIV infection has serious and direct implications for the quality of life of people with HIV/AIDS. Weight loss is often the event that begins a vicious circle of increased fatigue and decreased physical activity, including the inability to prepare and consume food and reduced work productivity.

In people with symptomatic HIV disease there are likely to be several overlapping processes taking place:

Reductions in food intake

This may be due to painful sores in the mouth. Fatigue, depression, changes in mental state and other psychological factors may also play a role by affecting a person's appetite and interest in food. Economic factors also affect food availability and the nutritional quality of food. Side effects from medications can also result in lower dietary intakes that can cause weight loss associated with HIV/AIDS.

Nutrient malabsorption

Malabsorption accompanies the frequent bouts of diarrhoea that affect people with HIV as a result of various infections. It is also believed that HIV infection itself may cause nutrient malabsorption.

Metabolic alterations

HIV infection results in increased energy and protein need as well as inefficient use and loss of nutrients. Changes in metabolism occur during HIV infection from severe reductions in food intake as well as from the immune system's response to the infection.

When food is restricted, the body responds by altering insulin and glucagon production, which regulate the flow of sugar and other nutrients in the intestine, blood, liver and other body tissues. Over time, the body uses up its carbohydrate stores from muscle and liver tissue and it begins to break down body protein to produce glucose. This process causes protein loss and muscle wasting.

Management of weight loss in HIV/AIDS is complicated by the fact that these three mechanisms are not mutually exclusive. Weight loss and wasting in people with AIDS may be the result of all three processes.

For the first two causes of weight loss and wasting, malnutrition can be reduced by treating the immediate sources of the problem (e.g. oral thrush,

mouth sores, other infections) and providing foods that are soft and well tolerated by the infected person. People with diarrhea should take plenty of fluids or use oral rehydration solutions to avoid dehydration and replace the lost fluids in the body. Also, if possible people with symptomatic HIV should try to eat as frequently as possible, even if the amounts of food are very small each time.

Nutrition is an essential part of any HIV care package. Nutritional care and support includes many components, and particularly when a person is asymptomatic, it must include an adequate quantity and quality of food. But improved nutrition is not enough in itself to permanently keep people healthy. History provides evidence of this, as in the late 1980s many people with HIV in the United States and other countries, developed opportunistic infections, progressed to AIDS and died, even though they had an excellent diet. However, good nutrition may help prolong the period of time between HIV infection and the onset of OIs.

In some communities affordable food supplementation may be feasible and it can have a positive impact on both body composition and weight. For example, The AIDS Support Organisation (TASO) has been distributing food to clients for 10 years as part of an overall community outreach response in Uganda.

With regard to vitamins and minerals, it is unclear to what extent these are helpful in the early stages of HIV infection. Several studies have been published on the role of vitamins and mineral in HIV disease progression and mortality. Primary associations were initially promising and micronutrient supplementation has the potential in a resource poor country to be an affordable and relatively easy to deliver public health measure. But the findings from micronutrient supplementation trials have however been mixed.

(For reading source, click [here](#).)

Impure Water

Those infected with HIV should make every effort to ensure that the water they drink is pure. As an individual infected with the HIV virus, one's immune system is more susceptible to contracting various infections and other diseases. Impure water is a source of where such infectious diseases may travel or originate; thus, it is ideal that HIV infected persons and AIDS patients drink water that is pure and free of such bacteria.

Contact with Animals

As is the case with impure water, animals are carriers of various diseases and infections that HIV/AIDS patients are more susceptible to because of the weakness of their immune systems. As a result, it is in the best interest of such infected persons to be aware of the animals in their surroundings. Be sure not to exchange any bodily fluids with animals and to be aware of meats consumed. Again, it is not necessarily that you may contract HIV from the animals; it is the fact that they may carry various diseases and infections that you are likely to contract if you come in contact with them.

Guidelines for HIV Infected and Affected Children

[Guidelines](#)

Guidelines ([PDF](#))

Please see the PDF file above for reference information on the wonderful organization who has provided these guidelines. The publications are designed for use by volunteer counselors, non-professional counselors, and professional counselors who do not have extensive experience in counseling in the context of HIV and AIDS.

The guidelines are the result of workshops organised under the SAT (School Without Walls), bringing together professional counselors, people living with HIV or AIDS, staff of AIDS Service Organizations and people working in the field addressed by the publication. Much of this information came from a workshop on counseling children with HIV or children affected by HIV and AIDS, facilitated by Jonathan Brakarsh and Clare Rudd of the Family Support Trust (FST) of Zimbabwe. These guidelines reflect the experiences

of the counselors and activities who participated. Virginia Knight Tyson and Sarah Lee provided editorial assistance. Joel Chikwara drew the cartoons.

To date, SAT has published counseling guidelines in English and Portuguese on the following subjects:

1. Disclosure of HIV Status
2. Child Sexual Abuse
3. Palliative Care and Bereavement
4. Domestic Violence
5. Survival Skills
6. Basic Counseling Skills

SAT is a project of the Canadian International Development Agency delivered by the Canadian Public Health Association. It has been at the forefront in supporting the community response to HIV and AIDS in Southern Africa since 1991. School Without Walls is an initiative to validate, promote and diffuse southern African experience and expertise in responding to HIV and AIDS.

HIV-AIDS Course, Chapter 6 - Care for AIDS Orphans

Statistics about AIDS orphans

The issue of AIDS orphans, according to the World Bank and other global agencies, is one of the largest impacts of the pandemic.

13 million children have lost their mother or both parents to AIDS, 10.4 million of whom are under age 15.

Many of the orphans alive today may die of AIDS.

Projections indicate that in 2010, 79-94% of orphans (of any kind) will be the result of AIDS mortality.

Orphans are among society's most vulnerable children. They suffer the trauma of seeing their parents die, and have been orphaned several times over as they witness the death of caretakers that have replaced their parents.

A study in Cote d'Ivoire showed that when a family member had AIDS, family income fell by 52-67 percent and food consumption dropped by 41 percent, while in Zambia the epidemic contributed to a doubling of street children.

HIV-AIDS Course, Chapter 7 - Condoms and Controversy



Teachers in Dhaka

Research on Condom Use

Condom use is often seen as a tipping point in the success of HIV-AIDS education and prevention. This section describes the literature on the effectiveness of condoms in the prevention of HIV and AIDS.

Here are the facts, to date:

Consistent condom use is the most effective way to reduce exposure to HIV and other sexually transmitted diseases among sexually-active individuals. Two major, international health agencies (World Health Organization and UNAIDS) are standing by recommendations for condom use as a means to prevent transmission of HIV/AIDS and other sexually transmitted disease (STDs).

There are no marketed microbicides or vaccines (with the exception of the Hepatitis B vaccine) for the prevention of sexually-transmitted diseases.

Latex condoms have demonstrated significant protection against diseases transmitted via penile-vaginal intercourse. STDs studied are: HIV infection, gonorrhea, chlamydial infection, [including gonococcal and chlamydial pelvic inflammatory disease (PID)], syphilis, chancroid, trichomoniasis, genital herpes caused by herpes simplex viruses (HSV)1 and 2, and genital human papillomavirus (HPV) infection and HPV diseases.

Resistance to Condom Use

One of the most controversial issues in prevention education is the varying responses towards use of condoms. The body of literature on the subject points to cultural and religious taboos; psychological implications (such as illusions of safety); views about condom effectiveness; increased risk behaviors correlating to promising research on treatment; and issues of male aversion. We shall address these responses below.

Condom Use

In the United States, where condom availability is pervasive, only 58% of sexually active youth use condoms.

Young people give the following reasons why they do not use condoms: a) embarrassment; b) a belief that it may affect sexual performance; c) concerns that a partner may be suspicious if a young man puts on a condom; d) an unrealistic optimism in one's personal risk of contracting HIV and other STDs.

The reason for unrealistic optimism may be due to several factors, not the least of which is a sense that by underestimating one's risk, a young man or woman can reduce the anxiety. It may seem to be counter-intuitive at first, but the greater the anxiety the young people feel, some studies show, the less chance there is that they will use a condom, for they fight fear by building up a psychological wall of protection. Such denial of vulnerability is not uncommon; many populations avoid uncomfortable emotions associated with health problems, an issue that is surely exacerbated in settings where health care options and treatment facilities are limited.

In developed countries, the introduction of more sophisticated drug therapies in HIV Positive treatment may be contributing to a rise of infections and risk-taking behaviors. Young people may rationalize that AIDS is treatable.

Role models (movie stars and sports figures) have engaged in a public relations campaign to restore pride and dignity to HIV-infected people ("I am Positive"). While such a campaign may be essential to ensure civil rights and active participation in society, an unintended consequence may be the elevation of one's HIV-Positive diagnosis as a status symbol.

Addressing Resistance to Condom Use - 2 Studies

There are several HIV-AIDS programs designed to change behavior. Some focus on facts where little information is available. Others try to infuse frightening messages about HIV-AIDS. Still others integrate the personal elements (showing the effect of knowing someone with AIDS on one's own behavior, for example).

Each HIV-AIDS program must be designed with evaluation techniques that use consistently accurate appropriate dependent and independent variables and analyses that can quantify the connection between education programs and changes in behavior.

As was shown in the Topic: "Resistance to Condom Use," attempts have been made to reduce feelings of invulnerability so that young people do not engage in unprotected sex. **The key is to integrate factual material with personal identification and engagement in order for the lessons to run deep.**

Two studies have been conducted with young people to determine the clues and strategies for helping them change their behavior. We have chosen to focus on these two approaches to HIV-AIDS education because they integrate personal engagement and good teaching. We stress that the creative presentation of programmatic materials is as important as the factual presentation of materials.

In the first approach, researchers focused on whether or not young people really "knew" about a person's HIV status, based upon a look at photographs and that person's brief statement about his/her sexual history. Many students were unable to produce an accurate score of HIV Negative and HIV Positive people. This study was based upon the idea that a student's sudden confrontation with his or her failed perceptions would change behavior. In this case, such a change would result in not relying on appearance and a statement from a potential partner. Protection would then take place as a matter of course.

It has been suggested that the study using photographs take on longitudinal elements by following the lives of young people pictured in the photographs for several months or years. In this way, several variables can be studied, including: a) a longer term analysis of the staying power of the exercise itself - is it continuing to work? b) a reinforcing of the point, such that subsequent groups of students participating in the photo-identification project could see the deterioration in the lives, over time, of those infected by HIV. A seemingly bright and beautiful face one day then turns into the face of disease.

In the second approach, researchers focused on negative health events as a compelling way of demonstrating a willingness to use condoms. In such cases, young people spoke about the STDs contracted. In addition, a 20-minute video was shown. Studies have shown an initial commitment to use protection, though it is not entirely clear whether or not the pressures surrounding participation in the study itself may not have had an effect on young people, who may feel pressured to provide the "appropriate," rather than the truthful, answer.

Both approaches were followed up by questionnaires at three and six months asking whether or not the young people had been sexually active in the intervening time and the degree to which they intend to use condoms.

FINDINGS & FOLLOW-UP

The intention of both studies is to reduce feelings of invulnerability and increase condom use. Both approaches showed demonstrable effects in reducing feelings of invulnerability and increasing the intention to use condoms. The results of this "stand-alone" intervention may be limited to some degree. The message remains. The teenagers' lack of ability to guess accurately the health of those in the photographs translated into a sense that: a) they may be wrong; b) the picture they viewed could, perhaps, one day be of them.

Future studies are being tested to overcome obstacles to condom use that extend beyond the perceptions of teenagers - availability in numbers and ease of access, social stigmas, myths about condoms, for example.

The post study is as important as the study itself, for the questionnaire itself is explicit about questions directed to young people about their own sexual behavior. These private issues are public insofar as the young people are participating in such a study and the follow-up surveys, which acknowledge their sexual activity. (We do not know what the drop-out rate is to determine the degree to which fear of such questions may have frightened some participants away.)

A conclusion that can be made, however (based upon a larger body of research in adolescent psychology) is that threatening or frightening images or programs showing the connection to and consequences of a particular behavior (in this case, unprotected sex) have been marginally effective, but short term. Recent studies have shown success in mitigating cigarette smoking amongst teens by showing dirty lungs, but the effects do not last because such messages are not personalized. Even more, some young people resist such messages as authoritarian and, therefore, go in the opposite direction - toward greater risk taking.

HIV-AIDS Course, Chapter 8 - Global Research in Education and Prevention

URLS

GENERAL (Online only)

[HIV-AIDS Search Engine](#)

[AIDS101.com](#)

[The Body](#)

[HIV InfoWeb](#)

[JAMA HIV/AIDS Information Center](#)

[University of California-San Francisco HIV InSite](#)

[Harvard Aids Institute](#)

INTERNATIONAL

[China Aids Network](#)

[Society for Women and AIDS in Africa's](#)

[International HIV-AIDS Alliance](#)

[International Council of AIDS Service Organizations](#)

[NAZ Foundation \(India\) Trust](#)

[Remedios AIDS Foundation \(Phillippines\)](#)

[AEGIS: AIDS Education Global Information Service](#)

[AIDS - Specific Country Profiles](#)

[AIDS International Training and Research](#)

[AIDS \(Acquired Immune Deficiency Syndrome\)](#)

[Journalists Against Aids International \(Nigeria\)](#)

[Women and Children:](#)

Clinical Short Course

This facilitator's guide presents new knowledge and skills for delivering and organizing clinical care and treatment services for people living with HIV/AIDS. It is shaped by Family Health International's longstanding work in HIV-related prevention, care and support activities in more than 60 countries. Recently, FHI began supporting public and NGO efforts to deliver strengthened HIV care and support, including antiretroviral treatment (ART), in three countries at the district level.

This work was supported by the U.S. Agency for International Development (USAID) through Family Health International's Implementing AIDS Prevention and Care (IMPACT) Project, Cooperative Agreement. The authors of this guide hope that it shall help clinical care trainers and providers develop the skills to ensure that their health care system provides high-quality HIV disease management, including the safe and effective use of ART.

[Clinical Course for Treatment of Persons Living with HIV-AIDS](#)

HIV-AIDS Course, Chapter 9 - Building Your HIV-AIDS and Sexual Education Program

Putting it Together



Your own program can meet
your needs

Strategies for Successful Programs

There are hundreds of reports that describe an overwhelming picture of the devastation that AIDS has brought to our world. However, there are several innovative programs that are making progress against the disease. It is important to note, though, that even the most successful of programs are limited unless:

- a) Funding is made available from government sources, NGOs, foundations, and businesses.
- b) Policies are created to support fair health treatment for all citizens in an atmosphere that does not punish or stigmatize infected populations.

Successful programs in schools and communities include at least one of the following elements:

- Teacher training in general and teacher training in HIV-AIDS.
- Support for the education system itself so that it is sustained, made available to all students, and includes a credible basic education program.
- Skill-based health education that promotes behavioral change.
- Special attention to girls - basic education and more leads to lowered infant mortality, higher productivity, fewer risk behaviors.
- School-based programs that involve youth-friendly services (sports, health, peer activities, use of technology).
- Focus on reaching all ages of students; the early years are essential, but should not stop there.
- Inclusion of parents as well as teachers - involving the entire community so that efforts in school are not undone later.
- Avoidance of stigma towards and associated with HIV-infected people.

UNESCO provides a clear analysis of the elements needed to develop a comprehensive HIV-AIDS education programme:

[UNESCO'S Strategy for HIV-AIDS Preventative Education](#)

PDF files below:

[UNESCO Strategy](#)

[Starting HIV-AIDS Programs 1](#)

[Starting HIV-AIDS Programs 2](#)

A special article on stigma associated with HIV-infected people:

[Stigma](#)

Worldwide Program Designs

Recommended Reading: [Promoting Reproductive Health in Uganda](#) :

Evaluation of a National IEC Program. Uganda has made great strides with its comprehensive approach. (HIGHLY RECOMMENDED. Available only online)

Please read the following website carefully for a specific look at the components of successful programs, worldwide:

[International Clearinghouse on Curriculum for HIV/AIDS Education](#)
(Online only)

PDF Resources:

Multifaceted Approaches

[For Health Educators: Prevention of Infection](#)

[For Health Educators: Health Care and HIV - A Nutritional Guide](#)

We have provided a synopsis, below, of various regional success stories. Here are several examples of what various countries are doing:

Zambia: Education for teacher trainees and school children, including anti-AIDS clubs and peer-led education approaches. Focus on community schools that include counseling and integration of HIV-AIDS awareness into service-learning projects.

Vietnam: Skill-based HIV-AIDS awareness program focusing on the facts of AIDS, coupled with an emphasis on tolerance, decision-making skills, and self confidence.

Zimbabwe: The AIDS Action Program for Schools, initiated by the Ministry of Education and Culture develops problem-solving, decision-making, and risk-averting skills. Strong involvement from both government and the church. Concerned about how teachers felt embarrassed teaching topics of sex and HIV, Zimbabwe developed the Auntie Stella health education pack for secondary school students in which the students themselves participate in the materials and design problem-solving activities.

Caribbean: The Health and Family Life Education program focuses on behavioral change by providing students with both facts and role-playing of real-life situations in class.

India: The Better Life Options Program focuses on adolescent girls through a combination of life skills, including literacy and vocational training, support for entering and staying in formal school, family life education, and leadership training.

Peru: This skill-based program focused on empowering youth with knowledge about sexuality and AIDS, toleration of people with AIDS, and prevention behaviors. The program was facilitated by trained teachers and implemented over 7 weekly, two-hour sessions with homework promoting interaction with family, friends, and local health institutions.

Uganda: The education programs have focused on a skills-based approach. Initially, the poor success rate of their health education program inspired innovative leaders to focus more on attitudes and behavioral change. The focus on teacher training (and ease with the material) helped to turn low results into high results.

Backgrounder

Suggested Reading: We STRONGLY suggest a re-reading of the website devoted to the successful and comprehensive program developed in [Uganda](#). (Online only)

Part of the difficulty associated with HIV-AIDS and Sexually-Transmitted Disease curriculum is that the materials themselves seem foreign to the teacher and distant from students' experience. UNESCO recognizes this problem as well and has developed a way to help teachers incorporate best practice and other resources into a program that makes sense on the local level. Here are the resources they provide:

Handbook for Curriculum Planners

There is increasing consensus about the need for AIDS education for young people. Studies have shown that sex and AIDS education may lead to a delay in the onset of sexual activity, and to the use of safer sex practices among those students who are sexually active. However, curriculum planners often lack examples of curricula, classroom activities and learning

materials. This resource package has been compiled to assist curriculum planners to design HIV/AIDS/STD education programmes for their own school systems, for students aged between 12 and 16. The program presented in this package is based on participatory methods, as these have been shown to be particularly effective for the teaching of behavioral skills.

[Introduction](#)

[Introduction](#)

[Designing the Program](#)

[Designing the Program](#)

[Curriculum and Teacher Training Materials](#)

This excellent section is devoted to the tools teachers will need in order to develop the program. It includes surveys with students, communications with and presentations to parents (including parent activities and surveys), peer-group exercises, leadership training exercises, assessment and quiz questions, scenarios and life situations to explore, and a needs analysis for future teacher training programs.

[Sample Curriculum and Teacher Training Materials](#)

[Programme Evaluation Instruments](#)

In this section, teachers have the resources they need in order to determine if students understand the material, are integrating the material, and are engaging in healthy behaviors. Of course, the surest judge of all is random testing, but that has to be done with the full approval and participation of health and legal authorities.

[Programme Evaluation Instruments](#)

Assignment 2: Designing Your Own Program

We are asking you to design, in broad terms, an HIV-AIDS Education program for your community. Please see the instructions on the ways in which you can provide us with the information (email, Personal File Storage, online survey, or by post).

Please follow the outline below, also repeated as an assignment for the Personal File Storage and included in the online survey:

Based upon what you have read, Teachers Without Borders would like you to create a program that meets your specific, regional needs.

Your Name

Project Leadership (Name, Email Address):

Country:

Program Title:

Outcome Measurement (Please see description on CD/Online). Please feel free to send in other pages via email, Personal File Storage, or by post:

How will this program be sustained? Parents? School? Political pressure?

What activities will engage students (beyond drilling them with facts) :

Will the program take place alongside of sports? arts? :

Will the program take place after school or part of the school program?

How does this program expand existing HIV-AIDS programs or replace it?

Have students design a logo. Describe it here and send it to us via an email attachment, in the post, or as a file you post to your Personal File Storage:

How will students serve as ambassadors to spread the word of the program?

What might the incentives be for youth to join this group?

Describe other possible incentives for students to participate :

How will student leadership be rewarded?

[HIV-AIDS Assignment 2](#)

New Roles for the Ministry of Education

The World Bank's report, "Education and HIV-AIDS: A Window of Hope," provides a guideline for Ministries of Education to make a positive impact on the AIDS crisis, summarized below:

Item	Action
POLICY	Argue the case for education as an urgent national priority and as a "high return on investment" sector that should be adequately funded, highlighting its crucial role in HIV-AIDS prevention and the grave dangers of inaction Ensure - and enforce - policies that make schools safe havens for children, including zero tolerance of sexual harassment and other inappropriate or criminal behavior, including on the part of teachers and school officials.

	Ensure close collaboration with other sectors (especially health, communications, and ministries dealing with youth affairs), recognizing that the fight against HIV/AIDS can only be won with multi-sectoral efforts Engage in systematic planning, developing the needed skills and methods and identifying key restraints to realize objectives as well as cost-effective ways to overcome the constraints. Ensure adequate arrangements for monitoring and evaluation, to measure not only progress in education outcomes but also the impact and spread of HIV/AIDS as well as the impact of preventative measures.
SUPPLY and QUALITY	Ensure an adequate supply of teachers, compensating for higher teacher mortality and absenteeism by increasing teacher training rates including through greater reliance on distance education; reducing the length of training courses; expanding in-service training to maintain quality; and recruiting teachers from non-traditional sources. Strengthen the delivery of prevention education by expanding in-service training in this area, emphasizing participatory and other innovative teaching methods that promote the teaching of

	life skills aimed at behavioral change; training youth (including those out of school) to be peer educators and counselors, and linking programs with health services. Adapt curriculum and learning materials, including health education messages early on and sustaining them throughout the education system, and focusing health education on life skills approaches that emphasize behavioral change and which are grade- and age-specific. Ensure an adequate supply of classrooms, identifying innovative scheduling alternatives where constrained resources limit new construction in order to keep pace with increases in the number of school-age children
DEMAND and ACCESS	Redouble efforts to ensure access to and completion of girls' schooling, with attention to water and sanitation needs and particular emphasis on orphans and other vulnerable children, through bursaries and other established approaches. Expand reliance on innovative approaches to reach out-of-school children, exploring distance education as well as community schools and other non-formal alternatives to provide education to rural or other inaccessible areas,

for counteracting the flight of teachers to urban areas (partly to avail themselves of better health facilities).